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The Fort Logan Mental Health Center is a new state hospital which will eventually serve half of the population of the state of Colorado. Its organization follows as much as possible the recommendations of the Joint Commission on Mental Illness and Health. Concepts of milieu therapy are strongly utilized, with the emphasis on expansion of professional roles and the involvement of the patient's family and his community as much as possible in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. One-half of its patients are in day care, and evening care is being instituted. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient through admission, treatment, and outpatient care.

EVALUATING GROUP THERAPY BY MEASURED CHANGES IN INTERPERSONAL RELATIONSHIPS*

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Within the past decade there has been an increased concentration of social caseworkers serving as group therapists in clinical settings and a focus on the use of group methods by social caseworkers in the schools of social work. The literature abounds with clinical evidence to the practicality and effectiveness of the group as a method of treatment, yet tested evidence is markedly absent. The purpose of this paper is to relate a study designed to evaluate the effectiveness of group therapy as a method of treatment by measured changes in interpersonal relationships.

From a review of the literature and from the writer's experience as a group therapist, the concept of interpersonal relationships seems to be the best single variable to measure improvement in group therapy (a) because of its general acceptance as a focal importance in the genesis and cure of psychosis and neurosis and (b) because it reflects the one aspect of personality functioning which is most strikingly disorganized in psychosis and severe neurosis (2).

The concept of adequacy of interpersonal relationships is conceived as being indicated by the capacity of the individual to form without anxiety and tension intimate and personal relationships with others which are satisfactory and rewarding to the

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**This study was conducted on The Continued Treatment Service of The Gulfport Division, Veterans Administration Center, Biloxi, Mississippi.

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individual and to the other party. This concept encompasses a broad continuum, ranging from the obvious avoidance of human contacts, epitomized by the psychotic patient huddled in the farthest corner of the ward in a neuropsychiatric hospital, neither looking at nor talking to anyone and apparently anxious to retreat even further from humankind, to that of the person who responds to another as a real person and not as a projection of his own emotional expectations (2). Between these two extremities, many shades and variations of interpersonal relationships exist, such as manifestations of the tendency toward a minimum of human contacts, keeping relationships impersonal and remaining aloof, being comfortable in relationships as long as social distance is achieved, and many others.

By definition, improvement in adequacy of interpersonal relationships can be achieved only by and through contact with others. Many persons are able to show improvement in interpersonal relationships through individual endeavors with a professionally qualified person, such as a social worker, psychologist, or psychiatrist. Improvement in interpersonal relationships can be optimistically enhanced for many others through a therapeutic group experience conducted under the leadership of a professionally qualified group therapist. The selected type of experience—individual or group—must, for the sake of the client, be made only after a thorough review of the client's past and present functioning and an evaluation of the needs of the client conducive to enhancing improvement in interpersonal functioning.

METHOD

Two groups, an experimental and a control, were formed to test the hypothesis that the results of the measurement of improvement in the adequacy of an individual's interpersonal relationships in a therapeutic group situation would indicate the effectiveness of this method to produce such an improvement. A p of .05 or less will be accepted as supportive of the hypothesis.

Patients were selected for study on the basis of their pregroup interpersonal behavioral level by the ward psychiatrist.

His criteria for selection were that the patients have an established diagnosis of schizophrenia of a chronic nature and that the patients, in his professional opinion, be functioning at about the same interpersonal behavioral level. Patients selected for study were randomly assigned to the two groups by the ward psychiatrist.

The membership of the two groups were composed of chronic regressed schizophrenic male Caucasian patients from the same ward on the continued treatment service of the Gulfport Division, Veterans Administration Center, Biloxi, Mississippi, a neuropsychiatric hospital.

The experimental group (composed of six members) was formed to measure changes in interpersonal relationships induced by group therapy. This group met twice weekly on Mondays and Thursdays for 60-minute sessions, for a total of 38 sessions. The control group (composed of seven members) was formed to evaluate changes in interpersonal relationships caused by factors other than group therapy and received no group therapy during the period covered by the experiment. To insure that normal ward procedures would be conducted and to avoid preferential treatment to members of either the control or experimental groups, ward personnel, other than the ward psychiatrist, were not informed of the experiment.

An analytical group-psychotherapeutic approach was used.* Material brought up in the therapeutic situation was related to and discussed in terms of the existing context or situation. This approach, as conceived by the author, differs considerably from the Rogerian nondirective approach. Since psychotic patients often communicate through disguised or symbolic terms, the writer has found that a directive and interpretative approach is more effective in improving interpersonal relationships.

The unit of measurement employed was the Palo Alto Group Psychotherapy Scale, which is designed to measure interpersonal relationships in group interaction. This scale, developed by

*An example of the approach used is given by the author in another article (1).

Dr. Ben C. Finney, was designed to meet the need for a sensitive, reliable, and valid measure of treatment success in group psychotherapy. Dr. Finney felt that while the global, clinical evaluation of progress in group psychotherapy is often adequate for many treatment situations, the need for a standardized measuring device becomes apparent when one attempts a scientific study of the processes and results of group psychotherapy (2).

The Palo Alto Group Psychotherapy Scale is composed of 88 brief descriptions of behavior which is likely to occur in a group therapy session, such as:

> Made faces and strange movements that did not make sense.
>
> Question, comments, or gestures show that he had some general idea about what the other members or leader was talking about.
>
> Kept bringing up a topic no one else was interested in.
>
> Talk seemed mainly determined by his own peculiar ideas.
>
> Usually talked to both the leader and to the other members.
>
> Directly asked for leader's opinion or advice.
>
> Added to the discussion of emotion by talking about his personal feelings and relationships.
>
> Kidded and joked in a friendly way with the leader.
>
> Did not respond or rejected an attempt by another member to be friendly.
>
> Remarks showed that he was trying to get a better understanding of himself and his problems.
>
> Asked about an absent member.
>
> Directly asked another member's opinion and advice.
>
> Steered the group into a good discussion.

The items in the schedule were found to discriminate at the .01 level between persons functioning at the lower, middle, and upper levels of interpersonal behavioral functioning. The reliability of the scale, as calculated on 41 patients by 15 judges, was .90.*

To ascertain the level of interpersonal behavioral functioning of each member in both the control and experimental groups, for each test period, each item on the Palo Alto Group Psychotherapy Scale was checked "true" (the behavior was exhibited) or "false"

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*Arguments for the validity of this test to measure interpersonal relationships are presented by Finney (2).

(the behavior was not exhibited). The final score for each individual, indicating his interpersonal behavioral level, was the percentage of all items marked in a way indicating "good" interpersonal relationships.

In order to reduce bias often interjected in the results through the use of different raters, the same rater was used in sessions of both the experimental and control groups. Objectivity in rating was further enhanced by not allowing the rater an opportunity to review the "key" to the scale, which indicated whether "true" or "false" responses reflected "good" interpersonal relationships.

FINDINGS

The testing of the control group and experimental group were started simultaneously. Both groups met for three sessions, and the Palo Alto Group Psychotherapy Scale was administered on the group members by the observer. The first testing revealed that the control group received an average score of 44.6 percent "good" responses and the experimental group received an average score of 43.5 percent. At completion of the study, the control group again met for three sessions and was tested. The experimental group, too, was tested by the observer on the basis of the last three sessions. Since the time element between sessions is considered to be significant as a factor in continuity, both the first and the last three sessions of the control group were spaced comparably with the time between sessions of the experimental group. At the final testing the control group received an average score of 48.8 percent "good" responses and the experimental group received an average score of 81.3 percent.

A t test for independent samples was run between the initial test scores made by the control group and the experimental group. The resultant nonsignificant t value of less than 1.00 suggests that the two groups were from the same population with respect to their initial scores on the Palo Alto Group Psychotherapy Scale.

A t test for correlated groups was run between the initial test

scores and the final test scores made by the experimental group. The resultant t value of 25.35 is significant at the .001 level of confidence. This finding demonstrates that the experimental group made significant improvement in interpersonal relationships.

The improvement in interpersonal relations made by the experimental group appears to be due to the experimental treatment (i.e., the 38 sessions of group therapy), inasmuch as a t test between the final scores made by the experimental group and control group yielded a t of 3.56 which is significant at the .01 level of confidence.

The improvement of the experimental group does not appear to be due to any general trend for the test scores to improve upon repeated testing, since a t test between the first and final scores obtained by the control group yielded a t value of less than 1, which is not significant.

In further evaluation to identify the period or periods of most significant change, exclusive of the first and last testing, the experimental group was tested by the observer after every fifth session. Scoring of the testing was based on behavior exhibited during each of the five sessions of the test period. The attained interpersonal relationship score for each group member is shown on Figure 1.

The first testing was compared with each of the remaining testings by using the t test for correlated groups.

The results are shown in Table 1.

TABLE 1

COMPARISON OF TESTING AFTER THIRD SESSION WITH SUCCEEDING TESTINGS

SESSION	t	p
3rd vs. 8th	2.82	.05
3rd vs. 13th	4.15	.01
3rd vs. 18th	10.16	.001
3rd vs. 23rd	9.97	.001
3rd vs. 28th	6.85	.001
3rd vs. 33rd	9.50	.001
3rd vs. 38th	25.35	.001

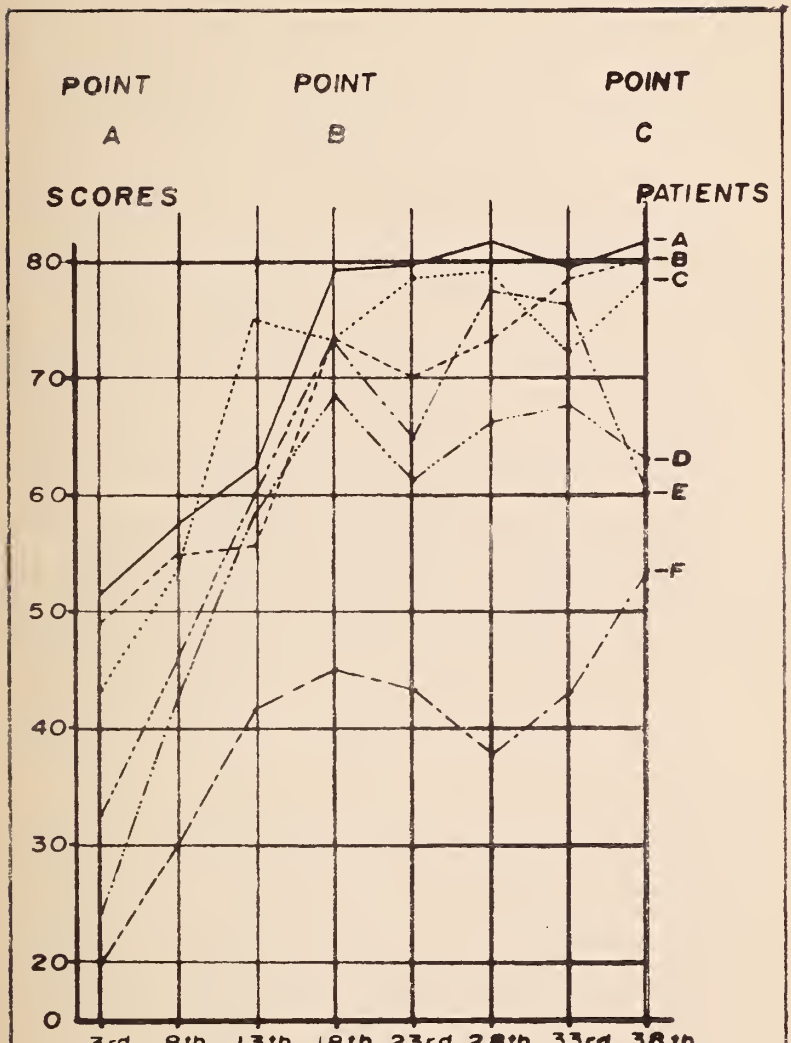

FIGURE 1. INTERPERSONAL RELATIONSHIP SCORES OF EXPERIMENTAL GROUP MEMBERS BY SESSIONS.

Point B (18th session) was selected as the point reflecting the greatest degree of change between Point A and Point C on Figure 1. A *t* ratio for correlated groups was applied to the scores at this point. The resultant *t* value of 10.16 is significant at the .001 level of confidence. Also a *t* ratio was used to measure changes between Point B and Point C with a resultant *t* of less than 1. (See Table 2.)

TABLE 2

COMPARISON OF *t* VALUE OF SCORES AT POINTS A, B, AND C

	t	*p*
Point C vs. Point A	25.35	.001
Point B vs. Point A	10.16	.001
Point C vs. Point B	<1.00	n.s.

These findings indicate that the experimental group made its greatest improvement in changes in interpersonal relationships during the first eighteen sessions and that improvement in changes in interpersonal relationships tended to level off without any significant change thereafter.

EVALUATION

In an attempt to evaluate areas in which there were changes, the 88 items on the Palo Alto Psychotherapy Scale were divided into the following categories:

A. Participating members who are involved with others:
   1. By "feeling out" or "fencing" to test the group in an attempt to establish satisfying relationships.
   2. By introspection, mutual criticism, and working through emotional problems with an awareness of and regard for the other group members as individuals.

B. Leadership qualities as exhibited by actively working toward the furtherance of the group.

C. Narcissistic participation aimed at self-gratification

and self-satisification.

D. Fringe members who do not become personally involved with other members of the group.

E. Nonparticipating members due to psychosis.

Categories A and B are related to the building up of group cohesiveness, and these factors are to be strengthened by the group process in order to obtain positive significance. Categories C, D, and E are related to the withdrawal tendencies and are to be lessened by the group process in order to obtain positive significance.

The *t* test was used to test the significance of differences between testing after the third session and the succeeding testings, as indicated in Table 3.

TABLE 3

COMPARISON CF TESTING AFTER THIRD SESSION WITH SUCCEEDING SESSIONS BY PALO ALTO PSYCHOTHERAPY SCALE CATEGORIES

	3rd vs. 8th		3rd vs. 13th		3rd vs. 18th		3rd vs. 38th	
CATEGORY	*t*	*p*	*t*	*p*	*t*	*p*	*t*	*p*
A1	3.78	.01	5.95	.001	6.25	.001		
A2	2.80	.02	6.16	.001	10.73	.001		
B	1.02	n.s.	2.30	.05	4.86	.001		
C	<1.00	n.s.	2.64	.05	3.40	.01		
D	2.60	.05	3.09	.02	3.86	.01		
E	<1.00	n.s.	<1.00	n.s.	1.75	n.s.	2.58	.05

After the 8th session positive changes were reflected at a significant level in three areas: Categories A1 and A2 (participating members who are involved with others) and D (fringe members who do not become personally involved with other members of the group). After the 13th session, all categories reflected significant change except category E (nonparticipating members due to psychosis), which reflected no significant improvement until the 38th session.

Although all items in category A are judged to measure the the same elements, this category was subdivided to indicate intensity of involvement. It was anticipated that category A1 (feeling

out or fencing to test the group) would realize a significant level of change early in the group sessions and that category A2 (introspection, mutual criticism, and working through emotional problems) would not achieve such a change until somewhat later, as this is the expected pattern in group formation. As expected, category A1 initially reflected the most significant change. However, it is interesting to note that the t value for category A2 is is higher than that for category A1 in each testing with the exception of the initial comparison. This finding indicates the earliness of this particular group's focusing on problem solving. Also after the 13th session leadership qualities emerged significantly.

After the 13th session the members who were narcissistically involved with self had changed significantly and were able to direct their attention toward the group. Also as indicated by the level of confidence of the t for the 8th, 13th, and 18th sessions, the fringe members were being slowly drawn into the group.

Even though there were tremendous changes in other areas of functioning, there were no significant changes in the members' exhibited psychotic behavior until the 38th session.

These findings approximate the philosophy expressed by Kindelsperger and associates at Tulane University School of Social Work. In Kindelsperger's six stages in group development, the group member begins to test out the group as he assesses possible social threats in an attempt to establish satisfying relations within the group. With some confidence after this initial testing out, the member begins to commit himself with emerging group roles on to the establishment of definite roles in the group. During this process leadership qualities are emerging and are being solidified into definite role patterns (3). In this group the testing out process had reached a significant level by the 8th session, group roles had been established by the 13th session, and leadership qualities had emerged significantly by the 18th session.

Spearman's rank correlation coefficient (rho) was administered to evaluate changes in order of rank between the beginning test scores and the last test scores. The resultant p value of .943 is significant at the .05 level of confidence, which substantiates the theory that group therapy is an effective medium of

treatment as it is supportive to all members of the group.

SUMMARY

In summary of the results, the control group and the experimental group were alike with reference to their initial test scores on the Palo Alto Group Psychotherapy Scale. The passage of time had no effect on subsequent scores made by the control group, but the experimental group scores improved significantly over their own initial scores, and also improved significantly over corresponding control group scores.

All areas of interpersonal relationships which were evaluated showed changes at significant levels of confidence. The development of leadership qualities and the establishment of group cohesiveness through mutually satisfying working relationships were the areas in which group therapy were the most effective. Those characteristics of self-involvement, withdrawnness and the exhibition of psychotic symptomatology were the least changed. The diminution of psychotic acts was the most difficult to accomplish through group therapy techniques.

These findings argue that interpersonal relations, as measured by the Palo Alto Group Psychotherapy Scale, significantly improve as a result of group therapy.

CONCLUSIONS

This experiment has demonstrated two important points in the use of group therapy as a method of treatment: (a) the effectiveness of group therapy as a means of improving interpersonal relationships and (b) the limitations of group therapy as a total treatment method. The first point is demonstrated by the over-all improvement in interpersonal relationships as manifested in group psychotherapy and, more specifically, improvement in areas considered to be "group function," such as involvement with others. The second point is demonstrated by the "flattening" or "leveling off" effect after a period of time and the difficulty in achieving improvement in areas considered to be "individual functions,"

such as those peculiarly related to the individual.

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MILIEU THERAPY: HISTORY AND INTERPRETATION

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INTRODUCTION

In order to discuss the history of milieu approaches to psychotherapy, it would seem wise to begin with some attempt at definition. It first must be said that although many writers have used the label "milieu therapy," this does not insure that they are dealing with the same concepts. A dictionary will provide one with *surroundings* or *environment* as a definition of "milieu" and *treatment* and/or *cure of diseases* as a definition of "therapy." It can readily be seen that such a definition, that is, one produced through the combination of the above two parts, leaves considerable to be desired regarding specificity and easily examined dictates. The present-day reviewers, theoreticians, and researchers in this social psychiatric field provide the reader with many diverse, yet elucidative, definitions. Cumming and Cumming (8) have defined milieu therapy as "the scientific manipulation of the environment aimed at producing changes in the personality of the patient." From a somewhat different theoretical framework than that employed by Cumming and Cumming, Rioch and Stanton (24) have stated that milieu therapy is a number of "procedures directed toward modification of the environmental part of the patient-environment process with a view to facilitating more satisfactory patterns of interaction, that is, transactions or relationships, in this process." Another very important researcher in the field, Alfred Stanton (26), views the essential characteristics of milieu therapy as including structuring of the hospital environment as much like the "outside" as possible, encouraging the patient's development toward freedom

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and spontaneity and autonomy, providing individualization of treatment, and, finally, having everything relative to the entire hospital or treatment setting governed by a master plan of a therapeutic nature. Reflecting more specific theoretical explanations, Wilmer (31) is concerned with providing both patients and staff of a hospital with "a sense of membership in this community," while Taylor (29) uses the term "therapeutic community" (a milieu therapy program initiated by Maxwell Jones in England) to "denote organizations in which permissive interpersonal and group relations are used as the main remedial agents." Jones and Rapoport (13, 14) feel that milieu therapy involves a strong commitment to the idea that socioenvironmental and interpersonal influences play crucial, though not exclusive, roles in a treatment program. In a practical sense, the therapeutic environment is characterized by an atmosphere of intimate and spontaneous face-to-face interaction in which lines of communication are relatively free, with both patients and the staff members having free access to the total body of relevant knowledge in the life of the institution. As a final example of some of the diverse approaches which have been taken in defining milieu therapy, the psychoanalytic school of thought, as represented by Main (16), views the therapeutic milieu as having its major curative effects through the "socialization of neurotic drives," their "modification by social demands" within a reality setting, general ego building or strengthening, and the "socialization of super-ego demands via group membership."

With the presentation of the above definitive statements it should be clear wherein the major problems of definition lie. Extracting from these and numerous other such statements, it becomes obvious that, at least in these theoretically oriented explanations, one very basic notion is common to all—*the surroundings of the hospital patient, both social and physical, are somehow directly related to whether or not his "mental" problems may be alleviated.* The entire environment of the patients, and this includes people, objects, buildings, and so on, ad infinitum, is seen as possessing a curative potential. At this point there are two crucial questions which may be raised: (a) What specific environment is most conducive to treatment of mental illnesses? and (b) By what means is such an environment therapeutic or curative? The definitions

offered above differ from one another primarily on the second question. In an effort to delineate the curative agents in a milieu deemed "therapeutic," these authors have dealt with personality structure, patterns of communication, permissiveness, and a sense of belonging, just to mention a few. It appears that throughout the last decade, considerable consensus has been established regarding the "what" of milieu therapy, but thus far, the "how" question has not been fully explored and there is no immediate agreement. It is encouraging to note that within the past three or four years competent discussions of this "how" question have been appearing in the literature with increasing frequency.

Returning to the first of the two questions, that which asks for an operational definition of milieu therapy, it may be said that in this area the literature has considerable to offer. A primary source of information may be found in the therapeutic community movement, started originally by the creative work of Maxwell Jones (11, 12), representing in all likelihood the most extensively practiced form of milieu therapy. When trying to put into practice present-day milieu therapy, one will encounter a long series of dictates, and a surprising majority of these have arisen from therapeutic community programs. At this point the reader is referred to the articles by Wilmer (30, 31) and the paper by Miskimins (18), both of which provide long lists of descriptions of a composite milieu therapy program. The dictates cover such variables as physical facilities, patients, staff, and group meetings. In essence, they attempt to clearly *define the patients to be placed in the milieu, milieu, and the nature and number of patient-milieu interactions.* Having considered the problem of definition, both operationally and theoretically, the subject of the historical sketch of many of the important events leading to today's conceptions of milieu therapy may now be approached.

HISTORY

It would be somewhat misleading to say that the milieu therapy movement started directly with the French Physician Philippe Pinel, although in a general sense that is accurate.

Near the end of the eighteenth century Pinel was appointed director of the Bicetre Asylum, the largest mental hospital in France. Pinel instituted an extensive, and now famous, humanitarian reform, eliminating such common primitive practices as chaining and beating. About the same time Benjamin Rush in America, William Tuke in England, and Fricke in Germany independently introduced similar reforms in their countries. By the early 1800's much progress had been made in all of these countries in introducing more modern methods and attitudes toward the mentally ill. Although this linkage of the humanitarian reform to milieu therapy is generally not considered direct, especially in terms of actual theory and practice, Adams (1) has recently pointed out that initially these humanitarian reforms brought about what has been labled "moral therapy," and this is not too dissimilar from milieu therapy as it is practiced today. Moral therapy was essentially a "program of planned psychological retraining within a positive, sympathetic social milieu." Adams further states that the "results of moral therapy . . . compare favorably with the very best mental hospital programs of today," and this fact has been supported by the works of Bockoven (4, 5), Brown (6), and Rees (23). It should be noted that the term "moral" was used at that time to mean something psychological or interpersonal or social, and stresses in these three areas were viewed as the "moral causes of insanity." These stresses were dealt with by friendly interpersonal relationships, discussions of patient difficulties, and the daily pursuit of purposeful kinds of activities. Although the results of these treatment procedures were genuinely remarkable, both in terms of the discharge rate (70 percent to 90 percent within a year) and readmission rates (less than 50 percent suffered recurrences), moral therapy was quietly abandoned in the 1860's, and later almost completely forgotten with only residual reform notions remaining. It seems reasonable to assert that moral therapy constituted the initial attempt at the type of treatment which is now being practiced under the rubric milieu therapy, given the fact that as now conceived it is more extensive in practice and couched in theoretical terms of a different nature. It is interesting to note that with the abandonment of moral therapy, the rates of cure for mental institutions began a steady decline,

having begun to rise again only during this last decade (Bockoven, 4), a decade witnessing the major strides of the milieu therapy movement.

Following a lapse of almost seventy years after moral therapy, once again events directly significant to the concept of the therapeutic community began to take place. A concern with the total hospital environment, or at least the social environment of a hospital, was reported by Ernst Simmel (25) working at the Tegel Sanitorium. He believed that the psychotic patient, and in particular the schizophrenic, must recapitulate the indulgence-frustration sequence which is hypothesized to have originally given rise to the reality principle by which the patient's ego is to function, in order to become cured of his illness. To bring this about, Simmel and his co-workers tried to arrange the milieu so that the patient was considerably indulged for a period of time, after which he would meet obstacles designed to produce frustration. During these same years, H. S. Sullivan (27, 28) worked at the Sheppard and Enoch Pratt Hospital. His particular contribution to the history of the milieu therapy movement stems from one significant observation—schizophrenic patients were not schizophrenic when they were with him. He felt that the social environment in this situation was in itself curative. Sullivan began to choose ward personnel for one particular ward with respect to their capacities for understanding and respecting the anxieties and the tangential communications of the patients, a skill he possessed and felt was important in the patient's differential reaction to him. The ward he used was special, segregated from the rest of the hospital, and it provided a "closed group," which the patient was invited to join. At this point Sullivan had very little contact with the patients, but rather he devoted most of his time to a "treatment-training" program with the nurses and attendents. Finally, it should be noted that these researchers attempted to evaluate their program, and they report a recovery rate at 85 percent for young first-admission schizophrenics.

The work of the Menninger Clinic (Knight, 15; Menninger, 17), starting in the 1930's, also seems relevant to the history of milieu therapy. The Menninger Clinic followed the classical medical paradigm as their approach to treatment; this involved basically an extensive and careful diagnostic work-up, on the basis of which

specific treatment procedures were prescribed. Of relevance here, this prescription covered most of the patient's milieu; for example, for a particular patient the attitudes of the various staff members around him were predetermined, certain kinds of recreational and/or occupational activities were prescribed, and so on. This work was done in a psychoanalytic theoretical framework, the prescription mainly in terms of diagnostically determined conscious and unconscious emotional needs. It is interesting to note that Menninger required staff members to consult with him, in order for them to work out any emotional problems that might be interfering with their developing appropriate relationships with the patients.

"Total Push" therapy (Myerson, 19) appears to have considerable in common with milieu therapy. Abraham Myerson devised this program to counteract the hospitalization reaction or "prison psychosis" which he felt "interacts with the social retreat of the original schizophrenia." Myerson had made the observation that whatever initiative a newly admitted patient might have was gone after a few months incarceration: "He is immersed in monotony and . . . he lives in a motivation vacuum." This researcher defined "Total Push" as a "thorough-going steadfast pressure of a humane and physiologically sound background," and he dictated a complex of measures to be taken: general medical measures, such as exercise, vitamins, and physiotherapy; and a concurrent psychological push, such as proper clothing, praise, blame, reward, and punishment. He advocated teaching such things as music, craftsmanship, dancing, and occupations, and he felt these would be utilized by the patients as they grew in their ability to take responsibility and in their general internal organization. Myerson's greatest contribution to the milieu therapy movement would seem to lie in his elaborate discussions of the antitherapeutic effects of the milieu presented by the traditional mental hospital.

One of the most influential movements in the history of the therapeutic community was that taking place at the Chestnut Lodge Sanitarium, in Rockville, Maryland. It was organized for the treatment of all functional psychotics with intensive psychotherapy, in the framework of psychoanalysis, and among its staff members have been Freida Fromm-Reichmann, David Rioch, Alfred Stanton,

and Morris Schwartz. In a paper by Dexter Bullard (7), who was the initial administrator, the topic of "optimum conditions" (therapeutically) in terms of certain specific features of the patient's environment is discussed at length. This environment was to provide understanding, therapy, friendly attitudes toward the patient, permissiveness, and relationships with others that meet the patient's needs. In order to provide an optimum environment, the staff instituted such practices as close contact between administrators and therapists, close collaboration of the entire staff, lectures and conferences with the nonprofessional staff members, some therapy for the nonprofessional staff members, and so on. It is worthy of note that Freida Fromm-Reichmann discusses such topics as the therapeutic importance of staff members other than the therapists per se and the importance of the patient's home and family milieu, in her book *Principles of Intensive Psychotherapy* (10). The work of these researchers at the Chestnut Lodge Sanitarium would seem to be extremely significant as early endeavors toward the therapeutic community as it is now conceived.

During the early 1940's at the Belmont Hospital in England, Maxwell Jones set up what would appear to be the singly most influential plan of community treatment in psychiatry. In his book *The Therapeutic Community* (12), he describes at length the problems encountered and procedures utilized in making the hospital community a therapeutic environment. His program was characterized by permissiveness, integrated community and small group therapy meetings, and generally, by a highly scheduled and active day for all patients. He introduced "social therapists" in place of nurses, and labeled the ward on which he was working the "social rehabilitation unit." The Rapoports, significant researchers and theoreticians in this field, presented several supplementary studies (20, 21) which are an important aspect of the entire Belmont investigation. Jones also did follow-up studies to examine the results of his treatment program.

In the field of child psychiatry, therapists soon became attentive to the milieu as a crucial factor in the child's therapy. This is witnessed in the now common procedure involving the placement of parents of disturbed children in therapy, on the grounds that they represent the significant parts of a child's social

environment. During the 1940's institutions for children began to be organized according to the conceptual model of the family, for example, by breaking up very large groups of patients into several smaller groups, each possessing its own staff to serve as regularly available parent figures. Anna Freud and Dorothy Burlingham (9), in a report on their work in England during World War II, described the dramatic effects which may be accrued by changing the organization of the milieu surrounding psychiatric patients.

The Cassel Hospital in England, under the direction of Main (16), was one of the very first institutions to introduce patient government. In an effort to compel the patients to handle community problems themselves, learn to take responsibility and the like, this researcher "risked chaos and anarchy" by suddenly and completely stopping all staff decision-making, and turning this function over to the patient population. According to Rioch and Stanton (24), during this same period of time the concept of the "psychiatric team"--consisting of psychiatrist, psychologist, social worker, psychiatric nurse, and head ward attendent—came into being. This product of the Neuropsychiatric Section of the Army Medical Service represents another approach to the problem of modifying the milieu toward therapeutic goals. Its effectiveness derives from the unification of interest, effort, and methods of the team members by instilling with them a "sense of mission" to be accomplished; Rioch and Stanton point out that "the effectiveness of the team is more than the arithmetic sum of the effectiveness of the separate parts."

Some of the first careful and complete clinical studies of milieu therapy were done in the area of the treatment of the emotionally disturbed adolescent by Bettleheim and his collaborators at the Orthogenic School of the University of Chicago and by Redl and his co-workers at Pioneer House and Wayne University in Michigan. Bettelheim (2) has proposed that older children upon being institutionalized identify the institution as a "home," with its implicit and unwanted demand upon the child for affection. He described in detail the operation of an organization which is therapeutic, and demonstrates the way in which child-staff interaction, even in routine activities, has therapeutic significance. With

Sylvester (3) he has presented his concept of "psychological institutionalism," a deficiency disorder in the emotional sense. This disorder is attributed to the traditional mental hospital environment which stresses depersonalized rules, order, compliance with rules at the expense of any spontaneity, lack of prolonged and close contact with any one person, and so on. Milieu therapy is characterized by an emphasis on flexibility and spontaneity and individualized interpersonal relationships within which all activities, simple or complex, are carried out. Redl and Wineman (22) proposed that a "psychologically hygienic atmosphere" is essential for the treatment of disturbed individuals. They concerned themselves with the modes of communication with the children and dictated that these should be consistently directed toward the end of developing a stable "sense of belongingness," both with the institutional group and with the entire community.

INTERPRETATION

At this point in the chronological sketch of the milieu therapy movement, the list of contributions will conclude. It would seem appropriate here, as means to conclusion, to stand back and approach in overview the events previously discussed. It should be noted, as is so often done in historical papers, that in all probability the list presented is not complete. Indeed it is virtually impossible to assemble all of the important influences, and certainly all of the minor influences, both published and unpublished, which have played a part in the development of a scientific movement such as this. Further, it should be stated that although the representative influence of various works was inferentially or directly proposed in this paper, this also presents a tremendous problem for the historian.

Considered in overview, milieu therapy today appears to represent the inevitable merger of two distinctively different and originally independent theoretical developments. The first of these is one which in its early stages is often labeled the "humanitarian reform," and today there still exists an influential modern-day extension of its postulates. The theoretical approach here is a

negativistic one, as it were, delineating one by one those aspects of existing patient environments which are directly antitherapeutic and/or immoral in the eyes of the larger society. The roots of this approach are seen, for example, in the previously cited work of Pinel who campaigned vigorously against several often-used forms of physical punishment. The change from the jail-like traditional psychiatric hospital began over 150 years ago, yet is still in itself an active movement. These humanitarian reform activities in toto serve as one of two originally independent theoretical movements which now are inseparably fused within mental hospitals' utilization of milieu therapy.

The second of the two influences is very adequately characterized by the previously cited work of Ernst Simmel (25). Having postulated certain dynamics as significant to the development of schizophrenia, he then, from a theoretical standpoint, proposed a certain series of psychological events leading to the alleviation of the illness. Following this he proposed the critical question: How might the patient's milieu be structured in such a manner as to increase the likelihood of the occurrence of the cure-producing psychological events? While humanitarian reform theory deals mainly with detrimental aspects of an environment, this second approach deals through theory with postulated beneficial aspects of a milieu. Here one ponders first the goals for a patient or a group of patients, second the ways in which various parts of the environment may implement these goals, and then, last, actually makes milieu manipulations and critically views the results. It can be seen that inexorably interwoven into this movement must be considerable theory; originally it was psychiatric or psychological, but more recently the theoretical contributions of social psychology, sociology, and to a lesser extent, anthropology, have been utilized.

The merger of humanitarian reform and the theoretically derived manipulation of the environment of the psychiatric patient seems indeed inevitable. With reform doctrine pointing to aspects of a milieu which are "bad," albeit in terms of morality and physical well-being, the second approach is on hand to provide substitute practices, that is, milieu aspects which are "good." There is of course the possibility of theoretical conflict here;

that is, it is conceivable that some particular practice may be unacceptable in the eyes of the prevailing culture, yet theoretically conceived as the most direct means to symptom alleviation. At this point the milieu therapy movement, having been given considerable impetus by reform movements, finds itself clearly bound by the latter, and for the most part presently is having to operate within the bounds of two differentially derived groups of dictates.

At present, milieu therapy has numerous strongholds throughout mental hospitals, both public and private. Whereas a decade ago such milieu therapy programs as Maxwell Jones described in *The Therapeutic Community* (12) were considered to be extremely progressive, avant-garde, and sometimes just plain foolish, those existing today are being given serious attention by virtually all workers in the mental health field, often being studied as models for changes in existing traditionally oriented institutions. It seems reasonable to assert that after another two decades, milieu therapy in its more extensive forms, as exemplified by the therapeutic community, will become the rule rather than the exception as the means by which mental illness is treated in this country.

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SIGNIFICANCE OF THE CONCEPT OF SUPPORT AS REGARDED BY NURSING PERSONNEL

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INTRODUCTION

The use of psychological support as a treatment modality has frequently been identified as one of the primary therapeutic tasks of nursing personnel (1, 2). In discussing how support was utilized in a setting such as Fort Logan, the Nursing Role Research Committee** found that definitions of support varied and were often unclear. Because support is an approach to or a means of treating patients, the committee thought it would be useful to undertake a study to determine what some of its characteristics were considered to be by nursing personnel.

After finding how some of the components of support were described, the major goal of the study was to ascertain the importance of these factors in the thinking of members of the Nursing Department. For example, was encouragement (a frequently mentioned synonym) more important in the meaning of support than empathy? Another goal was to learn which diagnostic groups were perceived as requiring the most or the least support. The third aim was to see if nursing personnel saw interdisciplinary differences in the giving of support to patients. A final purpose

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**Assistance with the organization of the study and computation of the data was provided by the following members of the Nursing Role Research Committee: Vi Siewert, Belle Burnsed, R.N., Dan DeRose, and Martha Richards, R.N.

was to see if there were any differences between nurses and psychiatric technicians in their views of support.

The initial stage of the study involved having some members of the Nursing Research Committee question ten nursing staff members about the meaning of the term "support." Committee members wrote down as nearly verbatim as possible the respondents' answers, including examples given of instances where support had been used with patients. The responses were typed to preserve anonymity and were read by the committee's research consultant.

Examination of these data revealed that nursing staff answers could be summarized as either being one-word synonyms or descriptive phases. These two types of answers were utilized in the design of the questionnaire used to assess the significance of support.

SUPPORT QUESTIONNAIRE

Part I of the questionnaire listed the seven one-word synonyms of support which were commonly given in the preliminary questioning and asked respondents to rank them "in terms of how central or important" they thought the words were to the concept in question. The synonyms were: *encouragement*, *acceptance*, *reassurance*, *warmth*, *sympathy*, *constructive criticism*, and *empathy*.

Part II listed the same words and asked respondents to check on a five-point scale for each one how important they thought it was to the meaning of support. (A rank of 1 indicated the word was slightly important, while a rank of 5 indicated the word was extremely important.) The reason for handling these words in two different ways was that Part I would force staff to discriminate between them, even if staff would prefer not to make these judgments. That is, Nurse A might rank *encouragement* first and *constructive criticism* last in Part I, yet still feel both were extremely important in the meaning of support. Nurse B might rank *encouragement* and *constructive criticism* the same as Nurse A in Part I, but in Part II give them differing degrees of importance. Using the two scales in this way enabled the committee to investigate (a) the relative importance of these words to the idea of support and (b) the degree of their importance to individuals.

Parts III and IV used the same techniques of ranking and scaling applied to the eight descriptive phrases, which were: *helping a patient to do what he thinks he can't, staying with a patient when he is upset, understanding a patient's feelings and showing him it's okay to feel that way, pointing out reality while at the same time being sympathetic, reinforcing a patient's decision, providing opportunities for a patient to verbalize his feelings, showing the patient you care about him as a person,* and *reinforcing a patient's right to make a decision.*

Part V asked that the following categories of people be ranked "in terms of which you think are most supportive to patients," technicians, social workers, other patients, nurses, psychiatrists, and psychologists.

Part VI asked (a), "Which diagnostic group do *you* think requires (from a therapeutic point of view) the most support?" and (b), "Which diagnostic group do *you* think requires the least support?"

Members of the Nursing Research Committee pilot tested the instrument to see if there were unclear questions and if it was either too long or too short. The full-scale administration was accomplished at a Nursing Department meeting following this pilot test.

RESULTS

1. *Synonyms of Support*

Average ranks assigned by technicians and nurses to the words are shown in Table 1.

TABLE 1

AVERAGE RANK OF WORDS' IMPORTANCE TO MEANING OF SUPPORT*

	NURSES	TECHNICIANS
ACCEPTANCE	1.6	2.1
EMPATHY	3.4	3.1
REASSURANCE	3.5	3.3
ENCOURAGEMENT	3.7	3.4
WARMTH	3.9	4.3
CONSTRUCTIVE CRITICISM	5.2	4.9
SYMPATHY	6.6	6.7

*Low average rank indicates most importance.

From highest to lowest average ranks, both technicians and nurses ordered the words identically. (*Tau* is significant at $p < .00020$.) *Acceptance* was clearly seen as the most central notion to support, followed closely by *empathy*, *reassurance*, *encouragement*, and *warmth*. *Constructive criticism* was second from the bottom, and *sympathy* was least important.

Part II of the questionnaire tried to determine the importance of these words for support in a different manner. Average importance ratings for technicians and nurses are shown on Table 2.

TABLE 2

AVERAGE RATED IMPORTANCE OF WORDS IN MEANING OF SUPPORT*

	NURSES	TECHNICIANS
ACCEPTANCE	4.5	4.4
EMPATHY	4.2	3.7
REASSURANCE	4.1	3.7
ENCOURAGEMENT	4.2	3.8
WARMTH	4.2	3.7
CONSTRUCTIVE CRITICISM	3.7	3.4
SYMPATHY	2.5	2.1

*High mean ratings indicate greater importance.

While *acceptance* still was rated as most important and *sympathy* clearly was rated as least important, the middle five words were rated somewhat differently by technicians and nurses. Nurses apparently felt that there was little distinction among *acceptance, empathy, reassurance, encouragement,* and *warmth;* while technicians felt that *acceptance* stood out somewhat, and they did not distinguish among the next four words. *Constructive criticism* was added as being almost as important. By and large, there was little difference between the importance attached to the words in Part I (ranking) and Part II.

2. Descriptive Phrases of Support

The comparative mean rankings of the eight phrases in Part III for nurses and technicians are shown in Table 3.

TABLE 3

AVERAGE RANK OF DESCRIPTIVE PHRASES' IMPORTANCE TO MEANING OF SUPPORT*

	NURSES	TECHNICIANS
Showing patient you care about him as a person	2.1	2.2
Providing opportunities for patient to verbalize his feelings	2.5	3.6
Understanding patient's feelings and showing him it's okay to feel that way	2.7	3.0
Staying with patient when he is upset	4.8	4.5
Pointing out reality while at the same time being sympathetic	5.2	5.3
Reinforcing patient's right to make a decision	5.6	5.0
Helping patient to do what he thinks he can't	6.5	5.3
Reinforcing a patient's decision	6.7	6.8

*Low ranks indicate greater importance.

Technicians and nurses substantially agreed on the ranks of these statements in terms of how important they were to support (*Tau* is significant at $p < .0028$.) The agreement, however, was not perfect, as was true in the case of the synonyms. Results demonstrated that there was greater room for interpreting statements differently than interpreting single words.

Table 4 presents the average rated importance for these statements.

TABLE 4

AVERAGE RATED IMPORTANCE OF DESCRIPTIVE PHRASES IN MEANING OF SUPPORT*

	NURSES	TECHNICIANS
Showing patient you care about him as a person	4.8	4.2
Providing opportunities for patient to verbalize his feelings	4.8	4.0
Understanding patient's feelings and showing him it's okay to feel that way	4.5	3.9
Reinforcing patient's right to make a decision	4.1	3.8
Staying with patient when he is upset	4.0	4.0
Pointing out reality while at the same time being sympathetic	4.0	3.2
Reinforcing patient's decision	3.4	3.2
Helping patient to do what he thinks he can't	3.3	3.4

*High mean ratings indicate greater importance.

There was little substantial difference among these ratings. Nurses found *showing the patient you care about him as a person* and *providing opportunities for the patient to verbalize his feelings* of top importance. *Showing the patient you care about him as a person* was most important for technicians. *Helping the patient to do what he thinks he can't* and *reinforcing a patient's decision* were of least importance to both nurses and technicians, while technicians also rated *pointing out reality while at the same time being sympathetic* as being low on the scale of importance.

3. People Giving the Most Support to Patients

Table 5 presents the average ranks assigned by nurses and technicians to the people listed in Part V of the questionnaire.

TABLE 5

AVERAGE RANKS OF PEOPLE GIVING MOST SUPPORT TO PATIENTS

	NURSES	TECHNICIANS
TECHNICIANS	2.2	2.0
NURSES	2.3	2.2
OTHER PATIENTS	2.6	2.3
M.D.'S	4.3	4.4
SOCIAL WORKERS	4.5	4.2
PSYCHOLOGISTS	5.0	5.0

These six groups of people fall into only two discriminable categories if one distinguishes among them in terms of how much support they give patients. Technicians, nurses, and other patients clearly ranked high and were close together, while psychiatrists, social workers, and psychologists ranked low. Agreement between nurses and technicians on the sets of ranks was statistically significant. (The obtained *tau* yields a significance level of $<.0083$.)

4. Diagnostic Groups Requiring Most and Least Support

Table 6 gives the various diagnostic categories perceived as requiring the most and least support. Some of the categories, e.g., character disorders and sociopaths, can be merged. However, the choice of words written in the questionnaire was preserved in setting up the table to show the variability of responses which were obtained.

TABLE 6

REQUIREMENTS FOR SUPPORT BY DIAGNOSTIC GROUPS

	MOST SUPPORT		LEAST SUPPORT	
	NUMBER	PERCENT	NUMBER	PERCENT
SCHIZOPHRENICS	18	30.0	2	4.0
DEPRESSED	17	28.3	2	4.0
REGRESSED	3	5.0	0	0
SUICIDAL	3	5.0	0	0
CHARACTER DISORDERS	3	5.0	13	26.0
SOCIOPATHS	0	0	9	18.0
DON'T KNOW	2	3.3	9	18.0
NEUROTICS	2	3.3	4	8.0
OTHER*	12*	20.0	11**	22.0
TOTAL	60	99.9	50	100.0

*Including two "psychodrama," one "nurses and technicians," one "technician," and one "large group" responses.

**Including two "all," one "social worker," two "O.T.," and one "evening activities" responses.

It is interesting to note that nursing personnel listed *regressed* and *suicidal* as diagnostic categories. Also note the starred *other* categories of response. Perhaps these were tongue-in-cheek responses or else represented misreading of the questionnaire.

DISCUSSION

The results of this study point to the fact that nurses and psychiatric technicians at Fort Logan share much the same meaning of the term "support," even when its meaning is ascertained by different techniques. Of course, since the psychiatric technicians at this hospital are trained by nurses, the investigator would expect to obtain more consensus between these groups than he perhaps might expect to find in a different mental hospital setting. Typically, workers in other psychiatric hospitals may be given different forms of training, and some programs may even be conducted by people little associated with ongoing treatment procedures. This situation should produce more variability in judgments between the two groups of nursing personnel.

Do other disciplines use the term "support" in the same sense as nurses? Again, while one would expect more agreement among disciplines *within* a hospital, there is less likelihood that two different hospitals would convey the identical meaning of support to their personnel. Current plans involve gathering data from another psychiatric setting to test these and other hypotheses.

Finally, support, as defined at this hospital, introduces many more undefined, perhaps variable, terms as it settles upon synonyms. While personnel agreed that acceptance tended to be a primary concern, there is no indication that *acceptance* is used to connote the same thing to all personnel. The statements made by nurses who were interviewed before constructing the questionnaire may provide a clue. When one shows the patient "you care about him as a person," one may be indicating acceptance of him. But how does a nurse *behave* when she is showing a patient she cares about him as a person? Do these actions involve spending a lot of time with a patient, listening with no attempt at interpretation, giving support by frequently agreeing with what the patient says, or by sometimes disagreeing and pointing out where he is wrong? Are there nonverbal cues common to support, acceptance, or empathy that are not found in sympathy and constructive criticism? Many semantic differences probably exist and have not been measured by this study.

SUMMARY

1. In an attempt to better define the significance of the term "support" as used by nursing personnel in therapeutic relationships, words with synonomous meanings were ranked as follows: *acceptance* first, *empathy* second, *reassurance* third, *encouragement* fourth, *warmth* fifth, *constructive criticism* sixth, and *sympathy* seventh.

2. Statements with synonymity were ranked also, but there was greater variability: ranking first, *showing the patient you care about him as a person;* second, *understanding the patient's feelings and showing him it's okay to feel that way;* third, *providing opportunities for the patient to verbalize his feelings;* fourth, *staying with a patient when he is upset;* fifth, *reinforcing a patient's right to make a decision;* sixth, *helping a patient to do what he thinks he can't;* seventh, *pointing out reality while at the same time being sympathetic;* and eighth, *reinforcing a patient's decision.*

3. Nursing staff felt that patients with schizophrenic reactions and those with depressions required the most support; character disorders and sociopaths were mentioned as the patients for whom support was least therapeutic. There was less consensus on the diagnostic groups requiring the least support than there was on those requiring the most support.

4. Nurses and technicians agreed that ranking of disciplines in terms of which give most support to patients was as follows: technicians first, nurses second, other patients third, psychiatrists fourth, social workers fifth, and psychologists sixth. The first-named three groups were very close together in average ranks, as were the last three.

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The author should include an address to which inquiries regarding the article should be sent, in the form of a footnote indicated by an asterisk on the first page of the article.

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